Rhode Island Executive Office of Health and Human Services
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May 6, 2015

Docket #15-325
Hearing Date: April 13, 2015

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s) following issue(s), rules(s), and regulation(s) were the matters before the hearing:

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)

R.I. MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION 1309.09: Overview of RIte Care Services

MEDICAID PROVIDER MANUAL: Dental

The facts of your case, the Agency rules and regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the appellant in c/o your mother), and Agency representatives Jack Demus and Robin Etchingham.

Present at the hearing were: Your mother, a Spanish Interpreter, and Agency representative Jack Demus.

ISSUE: Does the appellant child qualify for Medicaid covered comprehensive orthodontic services?

Rules, Regulations, and Guidelines:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services (EOHHS) Medicaid Code of Administrative Rules (MCAR) and Medicaid Dental Provider Manual

APPEAL RIGHTS:
Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The Agency representative testified:

- The Agency denied a request for prior authorization for comprehensive orthodontic treatment for the appellant child.
- On October 29, 2014, the Department's orthodontic consultant, Dr. Brennan, reviewed a prior authorization request submitted by the child's doctor, Dr. Silverberg.
- The State's orthodontist used what is called a HLD scoring index, which is used to measure the severity of the condition.
- An HLD score of 20 or more is needed to qualify for treatment.
- The State's orthodontist's HLD score is based on measurements and photos submitted by the child's doctor
- Part A of the HLD index lists severe conditions. If any of the conditions were found to exist, no further scoring would have been necessary and the child would have qualified for the requested service.
- If no condition exists in Part A, then Part B is scored.
- Part B is where measurements are taken.
- The appellant child scored a 4 for overjet, which is when the teeth flare forward.
- The appellant child scored a 2 for overbite, which is when the top teeth cover the bottom teeth.

- There was no score for eruption of teeth.
- For anterior crowding, the appellant scored a 10, which is the maximum score allowed.
- The total score in Part B was 16, which falls below the score of 20 that is needed to qualify for treatment, so the State's orthodontist denied the prior authorization request for treatment.
- For orthodontic treatment to be approved, the child's condition must be severe and handicapping.

The appellant's mother, with the assistance of a Spanish Interpreter, testified:

- Her daughter's bottom teeth are very crowded and some are twisted.
- She also has a tooth that is coming in that is not the same. It is not even with her other teeth but is stuck up inside.
- She would like time to have her orthodontist review and respond to the HLD score.

FINDINGS OF FACT:

- The appellant is a Medicaid eligible minor child.
- Steven W. Silverberg, DMD, submitted a request for prior authorization for comprehensive orthodontic services for the minor appellant child.
- The Agency sent a notice to the appellant dated November 7, 2014 informing her that Dr. Silverberg's request for prior authorization had been denied for failing to meet the HLD score.
- The appellant child's mother filed a timely request for hearing on her behalf, received by the Agency on November 25, 2014.
- The appellant's mother failed to appear for the scheduled March 3, 2015 hearing.
- The appellant's mother was sent a Notice of Abandonment dated March 4, 2015.

- The appellant's mother responded to the Notice of Abandonment in person on March 16, 2015 claiming she had good cause for failing to attend the March 4, 2015 hearing and an Appeals Officer approved the rescheduling of the Administrative Hearing.

- The Administrative Hearing was convened on April 13, 2015.

- Per the appellant's request, the record of hearing was held open, through the close of business on April 27, 2015, for the submission of additional evidence.

- Additional evidence was received in the Appeals Office on April 24, 2015, made part of the record of hearing, and a copy was provided to the Agency.

- The Agency informed this Appeals Officer by email on April 27, 2015 that the Agency decision to deny prior authorization remained unchanged as the evidence submitted while the record of hearing was held open was the same information previously submitted to and reviewed by the Agency prior to the denial.

- A letter dated April 28, 2015 and a copy of the Agency's April 27, 2015 email was mailed to the appellant in c/o her mother.

- To qualify for Medicaid covered comprehensive orthodontic services, the requested service must be medically necessary and required to correct a handicapping malocclusion.

- A HLD (Handicapping Labiolingual Deviation) score of 20 or more demonstrates medical necessity.

- The appellant has a HLD score of 16.

CONCLUSION:

The issue to be decided is whether the appellant child qualifies for Medicaid covered comprehensive orthodontic services.

The Agency received and denied a request for prior authorization from Steven W. Silverberg, DMD for comprehensive orthodontic services for the appellant child. The Agency does not dispute that the appellant child's Medicaid health coverage includes a dental benefit, but argues that the appellant child does not meet the medically necessary criteria for orthodontic treatment. The Agency testifies that for orthodontic treatment to be

approved, the appellant child's condition must be severe and handicapping as represented by the existence of certain conditions or a HLD (Handicapping Labiolingual Deviation) score of at least 20. The Agency submits a HLD Index–Orthodontic Diagnostic Score Sheet, completed and signed by the Agency's reviewing Orthodontist, Dr. Brennan, and testifies that Dr. Brennan scored the child's condition based on the measurements and photos submitted by her orthodontist. According to the HLD Score Sheet, Dr. Brennan concluded that the appellant child had none of the conditions listed in Part A that would have automatically met the medically necessary standard. In Part B the child was given a score of 4 for Overjet, 2 for Overbite, the maximum of 10 for anterior crowding, and 0 for ectopic eruptions, for a total score of 16.

Per the Medicaid Code of Administrative Rules (MCAR), Medicaid-covered services must be medically necessary, meaning they must be required to prevent, diagnose, cure, or treat a health-related condition. The Agency's Medicaid Provider Manual for Dental Services also stipulates that Medicaid payments will be provided only for covered dental services that the Agency's Medicaid Program, as the final arbiter, determines to be medically necessary. The Provider Dental Manual further stipulates that orthodontic services are limited to medically necessary services that are needed to correct a handicapping malocclusion in individuals under the age of 21. A handicapping malocclusion is defined as an occlusion having an adverse effect on the quality of the individual's life, including such things as speech, function, and/or esthetics that could have sociocultural consequences. A HLD (Handicapping Labiolingual Deviation) index is used to determine the degree of malocclusion to determine if and to what extent it is handicapping and whether orthodontic services are medically necessary.

While the Agency testified that the appellant child's HLD score was based on measurements and photos submitted by her orthodontist, only photos were submitted into the record. The appellant's mother was thereby given the opportunity to submit additional medical evidence post hearing and she submitted additional diagnostic evidence from the child's orthodontist as to the degree of the child's overjet, overbite, and crowding. Specifically, Dr. Silverberg reported that the appellant child has an overjet of 4mm, an overbite of 20%, and moderate crowding of both the maxillary and mandibular arches. He reported no ectopic eruptions or any evidence to suggest that the appellant had any of the qualifying medical conditions as listed in Part A of the HLD scoring index. In summary, the HLD score provided by the Agency's orthodontist is consistent with the diagnostic information provided by the child's orthodontist and is thereby correct.

In conclusion, orthodontic services must be medically necessary and required to correct a handicapping malocclusion established by the existence of a specific medical condition or by a HLD score of at least 20. The evidence record establishes that the appellant child has a HLD score of 16. As the evidence record fails to establish that the appellant child has a malocclusion or condition that is so severe as to be considered handicapping, the requested orthodontic services are thereby not medically necessary.

After a careful review of the Agency's rules and regulations, as well as the testimony and evidence submitted, this Appeals Officer finds that the appellant does not qualify for Medicaid covered comprehensive orthodontic services. The appellant's request for relief is denied.

Debra L. DeStefano
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

(Pertinent excerpts)

Section 1309: RIte Care

1309.02 Scope and Purpose
REV: June 2014

Effective on January 1, 2014, Rhode Island is implementing a new eligibility system for individuals and families seeking affordable coverage funded in whole or in part by Medicaid, tax credits, and/or other public subsidies. The new system uses a single standard – modified adjusted gross income (MAGI) – to determine income eligibility for affordable coverage across populations. To facilitate the transition to the MAGI, the RI Medicaid agency has reconfigured these populations into four distinct Medicaid affordable care coverage (MACC) groups: families, pregnant women, children and adults without dependent children (See MCAR Section 1301.03). Eligible members of three of these four coverage groups – all but adults 19-64 otherwise ineligible for Medicaid – will be enrolled in a RIte Care health plan or, as applicable, RIte Share.

The purpose of this rule is to describe the RIte Care delivery system and the respective roles and responsibilities of the Medicaid agency and the individuals and families that are receiving affordable coverage through a RIte Care MCO.

1309.09 Overview of RIte Care Services

Individual and families enrolled in RIte Care receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider. Rules of prior authorization apply to any service required by the Medicaid agency. The extended family planning group is entitled only to family planning services.

Each RIte Care member selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care physician orders treatment determined to be medically necessary in accordance with MCO policies. Individuals in the Extended Family Planning (EFP) coverage group do not require a PCP.

01. Access to Benefits – Unless otherwise specified, members of all RIte Care coverage groups (MACC, Non-MAGI, and Non-Medicaid Funded) are entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. State-funded pregnant women are eligible for in-plan services only while pregnant and in the two month postpartum period. All other pregnant women are eligible for the comprehensive benefit package through delivery and for two months postpartum or post-loss of pregnancy. In-plan services are paid for on a capitated basis (fixed cost per enrollee per

month). The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

02. Delivery of Benefits – The coverage provided through the RIte Care is categorized as follows:
    - In-Plan Capitated Benefits, including: RIte Care Comprehensive Benefit Package; Extended Family Planning Services; Special Services for Severely and Persistently Mentally Ill (SPMI)
    - In-Plan Fee-for-Service Benefits
    - Out-of-Plan Benefits
    - Early Periodic Screening, Diagnosis and Treatment (EPSDT) Out-of-Plan Services.

03. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to Medicaid-covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either medical or mental health status. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

04. Early Periodic Screening, Diagnosis and Treatment (EPSDT) -- The EPSDT provision in Title XIX mandates that the Medicaid agency must provide coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening or at any other occasion, whether or not those services are covered by the State Medicaid Plan or the State's Medicaid Section 1115 waiver. This applies to members of the MACC group up to age nineteen (19), SSI-eligible children and young adults up to age twenty-one (21), including adults aging out of foster care up to age twenty-one (21). A young adult over age nineteen (19) who transitions from the MACC group for children and young adults to the MACC group for adults from age 19 to 64 also receives EPSDT services until age 21.

MEDICAID Provider Manual: Dental

DENTAL SERVICES COVERAGE POLICY

Introduction
Dental services are a benefit to eligible recipients under the Rhode Island Medical Assistance Dental Services Program.

General Policy Requirements
The Medical Assistance Program will only reimburse providers for medically necessary services. The Medical Assistance Program conducts both pre-payment and post-payment reviews of services rendered to recipients. Determinations of medical necessity are made by the staff of the Medical Assistance Program, trained medical consultants, and independent State and private agencies under contract with the Medical Assistance Program. Services that are denied by Medicare because they are not medically necessary are not reimbursable by the Medical Assistance Program.
Providers must bill the Medical Assistance Program at the same usual and customary rates as charged to the self-pay general public. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to Medical Assistance. Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program.

Purpose of Coverage Policy
The purpose of this policy is to establish the rules of payment for services provided to individuals determined to be eligible for medical assistance under the Medical Assistance Program. The General Rules for the Medical Assistance Program and the rules in this policy are to be used together to determine eligibility for services.

Medical Necessity
The Medical Assistance Program provides payment/allowance for covered services only when the services are determined to be medically necessary.

The term "medical necessity" or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a detrimental change in either medical or mental health status.
Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

Appeal of Denial of Medical Necessity
Determinations made by the Medical Assistance Program are subject to appeal by the recipient only. Providers may not appeal denials of Medical Necessity.
Procedures are available for individuals who are aggrieved because of an agency decision or delay in making a decision of medical necessity. The route of appeal for Title XIX recipients is through the Department of Human Services. RIte Care participants may first appeal through the managed care plan, or may appeal directly through the Department of Human Services.
(Appeals rights and procedures are contained in DHS Manual Sections 0110 and 0348.)
Medical Assistance payments are provided only for covered services that are determined to be medically necessary. No Medical Assistance payment will be made for a medical procedure of an investigative or experimental nature.

Determinations of Medical Necessity

Determinations that a service or procedure is medically necessary are made by the staff, consultants and designees of the Health Care Quality, Financing and Purchasing Division, and by individuals and organizations under contract to the Department of Human Services. Policies relative to medical necessity are set forth in the DHS Manual, the Medical Assistance Program Provider Reference Manuals, and the Rhode Island State Plan under Title XIX of the federal Social Security Act. Medical necessity can be determined on procedure-by-procedure basis.

Approval of Medical Necessity

The Medical Assistance Program and its designees determine which services are medically necessary on a case-by-case basis, both in pre-payment and post-payment reviews, and via prior authorizations. Such determinations are the judgment of the Medical Assistance Program. The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. The Medical Assistance Program is the final arbiter of determination of medical necessity.

ORTHODONTIC SERVICES

Orthodontics is medically necessary services needed to correct handicapping malocclusion in recipients under age 21. The HDL (RI Mod) Index (Handicapping Labio-lingual Deviation Index) is applied to each individual case by Board qualified orthodontic consultants to identify those cases that clearly demonstrate medical necessity by determining the degree of the handicapping malocclusion. The HDL Index is a tool that has proven to be successful in identifying a large range of very disfiguring malocclusions and two known destructive forms of malocclusion (deep destructive impinging bites and destructive individual anterior crossbite). *Please see example HDL scoring sheet at the end of this section.*

Handicapping Malocclusion

An occlusion that has an adverse effect on the quality of a person's life that could include speech, function or esthetics that could have sociocultural consequences. Examples would be significant discrepancies in the relationships of the jaws and teeth in anteroposterior, vertical or transverse directions.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.